Hospice Notification Form

Purpose: For a hospice agency to notify HP Enterprise Services of any hospice recipient enrollment, discharge, change or recertification. Fax this form to HP Enterprise Services **within 72 hours** of new or changed information.

Attachments: These attachments **must be submitted with this form**: 1) certificate of terminal illness, 2) election of hospice services and 3) updated physician orders for recertification. If the recipient is residing or will reside in a Nursing Facility, a PASRR screening and LOC Determination Letter must be attached in addition to the documents listed above.

Fax this form to: (866) 480-9903 For **questions** regarding this form, call: (800) 525-2395

SUBMISSION DATE *(date this form is submitted):*
HOSPICE AGENCY INFORMATION
Name: NPI:
Address:
Phone: Fax:
PHYSICIAN INFORMATION
Attending Provider Name: NPI:
Hospice Physician Name: NPI:
RECIPIENT INFORMATION
Recipient Name *(last, first, MI)*:
Address *(include city, state and zip)*:
Recipient ID: Medicare ID *(if applicable)*:
Date of Birth: Sex: ☐ Male ☐ Female
Phone: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
List the names of all of all other payors *(if applicable)*:
NOTIFICATIONS AND CLINICAL INFORMATION
Hospice Diagnosis: ICD-9 Code(s):
Hospice Enrollment Date: Recertification Date:
Certification Period: ☐ 1st 90 days ☐ 2nd 90 days ☐ 60 days
Revocation Date (hospice disenrollment): Transfer Date to New Facility:
Date of Discharge to Home, on Hospice: Date of Death:
Is the recipient currently residing in a Nursing Facility? ☐ No ☐ Yes – *If yes, complete next section.*
Other Services Currently Provided: ☐ Personal Care Services (PCS) ☐ Waiver Services ☐ None *If PCS or waiver services are being provided, you must submit a completed Form FA-24A, "Care Coordination for Hospice and PCS or Waiver Services."*
NURSING FACILITY INFORMATION *(Required if recipient currently resides in a Nursing Facility.)*
Name: NPI:
Address:
Phone: Fax:
Is the recipient residing in a Medicaid bed? ☐ No ☐ Yes
SUBMITTER INFORMATION
Signature of Person Completing this Form:
Date: Phone: